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The Journal of the
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Allergic Rhinitis
Impacted Cerumen
Cultural Medicine
Medical Sociology

Medical Book News Editorials

Contemporary Progress

Vol. 71 No. 7

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EDITORIALS

Return of Slavery

BEFORE "the war between the States" the black worker was taken care of "from the cradle to the grave." In those days we called this social-security status slavery.

In return for the new social security "from the womb to the tomb," people must cede power to the State to order their lives, or the State may seize the power. In either case there is similar loss of liberty.

Those who insist that expanded social security, including compulsory sickness insurance, is a good thing, should logically insist, likewise, that the old institution of slavery must have had its admirable points. Indeed, some of the arguments in its favor when it was in effect and under attack, as they could easily verify, were impressive to most people and convincing to some. We fancy that many people today have not looked into the matter very carefully and tend to assume that the defense of slavery was weak and inept; actually, it was devilishly clever.

These old arguments should be restudied and refurbished by the friends of expanded social security; they should yield much ammunition for proponents and apologists.

Under a "cradle-to-the-grave" régime a paternalistic government would do for the individual what he should do for himself, which means, obviously, slavery of a sort, since the vast power then wielded by the State over its trapped minions seems certain to be abused.

Time would effect in the personality of successive generations of slaves a weakening of those endocrinous factors which now stamp man with characteristic traits —ambition, will, acquisitiveness, combativeness, individualism. An acquired docility and a slave brand of happiness would remove a bothersome challenge to any ruling master caste.

Physicians identified with such a "New Order" could not themselves escape its deadly effects.

Japanese Medicine

IT was Commodore Perry's work in Japan (1854) which accounts for the awakening of medical science in that country. Fearing invasion, the Japanese were obliged to prepare for the treatment of gunshot wounds. They had translations made of foreign treatises on such injuries, with which they were completely unfamiliar. This, of necessity, led to broader considerations of medicine, and their system (borrowed from the Chinese, like practically all of their culture) began to give way.

The first government hospital was established at Nagasaki in 1857. Another one was established in the '70's at Tokyo. Both were in charge of foreign physicians. There was a great demand for teachers from the Occident. In 1875 an edict was promulgated that licenses for the practice of medicine would thereafter be granted only to those qualifying in Western medical science. The last quarter century has seen the establishment of twenty-seven modern medical schools (most of them with graduate departments) and over a thousand hospitals, while there are at least 50,000 physicians in the country. Two schools train women. There are many medical societies and about fifty medical periodicals. One may safely say that Japanese therapy and research follow the best modern standards and much original work has been done. Familiar names are those of Shiga (dysentery bacillus), Takamine (adrenalin), Kitasato (*B. pestis*), Noguchi (culture methods), Yamagiwa and Ishikawa (coal tar cancer), Hata (Ehrlich associate on salvarsan), Inada and Ido (infectious jaundice), Futaki (rat-bite fever), Katsurada, Fujinami, Miyairi and Suzuki (*Schistosoma japonicum*), Yokogawa and Muto (*Metagoni-*

mus yokogawai), Kobayashi and Nakagawa (*Clonorchis sinensis* and *Paragonimus westermanni*). Advanced research is carried on by the Institute for Infectious Diseases, the Kitasato Institute, and the Institute for Nutrition. As long ago as 1925 Japan's sanitary standards were rated "higher on the whole than those of one or two Great Powers in Europe" (Rajchman, speaking under the auspices of the League of Nations).

Such facts, on their face, would lead one to suppose that sick and injured prisoners would be well cared for. As to nourishment, basic in this connection, the *New York Times* of May 18 stated that prisoners in an internment camp in Hong Kong in June, 1942, received an average daily ration of 4.91 ounces of beef, 5 8 ounces of sweet potato, 0.42 ounce of sugar, 0.42 ounce of salt, 0.30 ounce of peanut oil, 7 ounces of rice, and 1.5 ounces of cabbage.

Abortion in Feminine Personnel of Southern War Plants

THE Planned Parenthood Federation of America, Inc., alleges that abortion, under the guise of "sick leaves," accounts for much of the absenteeism in Southern war plants employing women. In some factories it is alleged by the federation that as much as 90 per cent of the absences are so caused. This is said to be because pregnancy may mean discharge. There are about 6,000,000 women in the nation's war plants. The federation estimates that in the nation at large there are from 8,000 to 10,000 deaths annually due to illegal operations and that "at least eight women are rendered sterile for every one who dies," and expects that these figures will be considerably increased by what is transpiring among the war plants' feminine employees.

The United States Department of Labor found in one war plant employing 20,000 women that 18 per cent of its women employees had been pregnant, of whom 2.5 had resorted to abortion. In the light of this survey the federation's estimate seems open to question.

The federation makes the following suggestions:

1. Abandon the practice of dismissing expectant mothers as soon as pregnancy is reported.

2. Permit expectant mothers to work as long as their health permits under adequate medical supervision during the time on the job. (Women can work up to the eighth month of pregnancy without endangering health if the work is not too strenuous).

3. Give assurance of re-employment after the baby is born and of the retention of seniority privileges.

4. Give medically supervised child-spacing information to those married women who wish to postpone pregnancy either because of poor health or inability to care for another child at the time.

The last suggestion seems to throw doubt on the federation's sincerity in making the first three recommendations.

The Threat of Bureaucracy

KENNETH C. CRAIN, of the Hospital Management magazine, sees probable damage to, or even destruction of, both voluntary hospitals and the Associated Hospital Service if the Social Security Board succeeds in expanding its program for government hospitalization insurance of the compulsory, payroll-tax type. Voluntary action would go out of the window if the bulk of our population is taken willy-nilly on such an all-out insurance ride.

What would be the effect of bureaucratic control, directed from Washington, upon our hospitals; how would present medical personnel be affected; and how well would the sick fare?

Dafoe of Callander

THE strong light of publicity that played upon Dr. Allan Roy Dafoe only served to reveal the best traits of the traditional general practitioner. He typified the public conception of that medical character and "his brother practitioners will be grateful to him for having represented them so well."

Care of Veterans at Saratoga

THE United States Veterans Administration is now operating one of the Roosevelt Bath Houses at Saratoga as a mineral water treatment unit solely for veterans, with early results that are strikingly successful. This logical use of the spa's therapeutic resources was foreseen early by the medical director of the spa, as we indicated editorially in the June, 1942 issue of the MEDICAL TIMES, when we said:

For no good reason, the great value of spa treatment like that, for example, provided at Saratoga Springs, has not been fully realized by the public or profession. The war now in progress will compel complete recognition and utilization because the spa's methods of rehabilitation meet adequately the requirements of both the civil and military populations with respect to many injuries and

chronic diseases. Convalescence from wounds and diseases can be ideally dealt with in many instances by well-equipped spas. As centers of recreation for army and navy personnel on furlough the spas will also receive, undoubtedly, governmental consideration in days of war to come.

Bearing on this subject is McClellan's recent article in the Archives of Physical Therapy, 22:656, November, 1941. This article may be found abstracted in our March, 1942 issue, with a comment by Dr. Norman E. Titus.

A Timely Proposal

MR. Charles M. Hendricks, of El Paso, Texas, Chairman of the Council on Military Affairs and Public Health of the American College of Chest Physicians, has offered a world plan for tuberculosis control that merits favorable consideration and action (*Diseases of the Chest*, IX, May-June, 1943, No. 3). He proposes that, in view of the fact that our armed forces will remain in Europe for an indefinite time after the war and in view of the existence of 10,000,000 cases of tuberculosis among the population, that our armies be accompanied by a trained medical personnel prepared to meet all local medical problems, especially tuberculosis problems. Dr. Hendricks believes that much more could be accomplished by specially trained control teams attached to the medical department of each army of occupation, with no waiting for various foundations to undertake the necessary tasks at a later date. These military control teams could at least blaze the trail and should information assembled by them reveal great problems of hospitalization and rehabilitation beyond the province and scope of the medical department of the army, such information could then be made available to the agencies and foundations prepared to take over and complete the work. Dr. Hendricks submits a blueprint of the plan outlining organization, purposes, type of information to be assembled, personnel of control teams, training of control teams, mission of control teams, equipment for control teams, and administration of control teams.

Conditions in such enslaved countries as Belgium, Poland and Greece are especially bad, but tuberculosis is spreading rapidly everywhere. The protection of our own troops is a basic consideration in Dr. Hendricks' plan.

Clash of Experts

OUR colleague Dr. Jonathan Forman, editor of the *Ohio State Medical Journal*, sees no sense in any American promise to feed the world after the war. He thinks we can help a little but not much, since:

"In our best years we raised about two-thirds enough food to set a decent table for our people—just a decent table, not the kind that nutrition experts feel is necessary to bring about robust health and resistance to disease. If we all stopped eating and gave all of our food to the other lands, which, of course, we could not do, we would be giving a sustaining diet to about 135,000,000 persons, and who is to feed the rest?

"Thus through our impossible promises we shall be called upon to say who in these foreign lands shall live and who shall die. In this way we increase the hatred which already exists towards us."

A. J. Carlson, of the University of Chicago, questions the lugubrious findings of the Federal Department of Agriculture as to the dietary deficiencies of the American people, upon which findings we suspect that Dr. Forman bases his judgment. Carlson points out that the Department's surveys do not give the amount of foods actually eaten or the amount wasted, and there was no physical or medical examination. Carlson reminds us that we do not know what percentage of our malnutrition is due to ignorance, to faulty food habits, or to poverty. "We do know," he says, "that it is not due to food scarcity."

Considering the difference in the views of these authorities, it would be interesting to know whether Carlson thinks it dangerous or feasible to promise to feed the world after the war.

Virus Research at Ann Arbor

THE National Foundation for Infantile Paralysis and the University of Michigan have joined in a long-range program for the training of doctors, public health workers and laboratory technicians to study infantile paralysis and other virus diseases. This program, which has been developing for three years, will be expanded in the University's new three-story building for its School of Public Health at Ann Arbor, Michigan.

INTERMEDIATE REPORT ON COLI METABOLIN IN ALLERGIC RHINITIS

ERNEST J. ELSBACH, M.D.
New York, N. Y.

IN 1941 there appeared a preliminary report on the treatment of hay fever through the use of Coli Metabolin (1). Therein we outlined the experience with its intramuscular use in allergic rhinitis in a series of 75 cases, in which at the end of a series of 12 injections 70.7 per cent of the patients were symptom-free, 28 per cent improved and 1.3 per cent remained unaffected. Compared with these results, Coli Metabolin was not successful at the hands of Schilkret (2), nor in the work of Loveless and Baldwin (3) had such results been duplicated. The latter, in attempting to duplicate our work, had used Coli Metabolin subcutaneously, whereas we had employed the intramuscular route. Their conclusion was formed on the basis of 20 cases, although some hundreds of reports from other physicians were available to them, most of which corroborated our findings.

This report concerns our treatments during 1941, which is conceded to have been a season with great exacerbations of hay fever symptoms in individuals sensitive to ragweed. Coli Metabolin was used at the onset of symptoms, and injected intramuscularly as an average series of 12 injections. The first 5 or 6 injections were given on consecutive days and the remainder on alternate days. Skin tests were not performed, as the cases in our clinical treatment gave a history typical of an allergic diathesis and a history of many former diagnoses of allergy by physicians previously consulted. Skin tests would, moreover, have served no special purpose, as one advantage of Coli Metabolin over specific desensitization lies in its effect, irrespective of the identity of the atopic agent. As Coli Metabolin is used at the onset of symptoms and not before, the patients presenting themselves for treatment were suffering acutely and manifested nasal findings typical of hay fever.

Two entities are tabulated in this report, namely, ragweed hay fever (table 1) and perennial coryza (table 2). Many of them had undergone previous treatment (tables 1 a and 2 a). The results of their former treatments according to the patients' own statements are listed in the following tables. Tables 1 b and 2 b show the results in those patients who were symptom-free through the use of Coli Metabolin, tables 1 c and 2 c of those who were improved and tables 1 d and 2 d of those who were not improved through its application. In tables 1 a and 2 a it is apparent that the majority of all cases who were unaffected by Coli Metabolin had undergone previous treatment without any improvement. With this relatively small number it is, of course, hard to say by what this resistance might be caused. Exhaustive investigations now in progress may shed light on the phenomenon.

In no instance were unfavorable effects reported by any patient, nor have deleterious results been observed by us, either in a systemic or local sense.

Three of the patients, who had good results with this treatment in 1941, underwent the same treatment again in August and September, 1942. Most of the patients, who answered our inquiry about their complaints during the ragweed season of 1942, and who had been treated during the same season in 1941, informed us that they were more comfortable than before starting treatment the year before and the previous years. Few had the same complaints. Of course the reason for their being more comfortable is doubtful as the ragweed season of 1942 was milder than that of 1941.

A few cases, which did not show rapid amelioration with Coli Metabolin, received in addition intravenous calcium injections with good results. Relief cannot have been due to calcium alone, because 2 patients had been treated with calcium alone in previous years without the slightest relief.

	Table 1. Ragweed Hay Fever	*Table 2. Perennial Coryza*
Total	47	13
Symptom-free	29 or 62%	9 or 69%
Improved	15 or 31%	1 or 8%
Not improved	3 or 7%	3 or 23%

Of these had undergone previous treatment:

	Table 1 a.	*Table 2 a.*
Total	26	7
Result of their treatment in 1941		
Symptom-free	13 or 50%	3 or 43%
Improved	11 or 42%	1 or 14%
Not improved	2 or 8%	3 or 43%

1941 symptom-free, previously:

	Table 1 b.	*Table 2 b.*
Symptom-free	0	0
Improved	2 or 15%	1 or 33%
Not improved	11 or 85%	2 or 67%

1941 improved, previously:

	Table 1 c.	*Table 2 c.*
Symptom-free	0	0
Improved	6 or 55%	1 or 100%
Not improved	5 or 45%	0

1941 not improved, previously:

	Table 1 d.	*Table 2 d.*
Not improved	2 or 100%	3 or 100%

I am quoting in brief some histories:

1. **E. B., white housewife, 44 years. Allergic rhinitis for 9-10 years, all year 'round. Tests made 1934 were positive to dust, dog, horse hair. Typical nasal findings. Treated 9/18-10/3, 1941. After second injection much less sneezing, but nose still blocked and running. After 5th injection fine but for slight sneezing. This had disappeared when discharged. When seen 2/10, 1942, was all right.**
2. **J. R., white male student, 18 years. Hay fever during ragweed season for 5 years. Previous treatments for sinusitis. Hay fever started about 8/7, 1941 in Virginia, improved upon his arrival in Westchester, but was bothered very much again since 9/7. Treatment 9/9-9/18, 1941 with 7 injections. After 2 injections much improved, symptomless when discharged. 9/29, 1941 felt the same way. This was especially interesting for a comparison, as a brother who did not undergo any treatment had the usual hay fever symptoms.**
3. **... E., white beautician, female, 32 years. Hay fever during ragweed season since 1939. She was given intravenous calcium injections, 1939 without any relief. Treated 8/26-9/15, 1941. Felt fine after second injection. As she complained, later on, that the nose was more blocked than after the first injections, she received calcium intravenously together with the 8th, 10th, 12th and 13th injection of Coli Metabolin with excellent results. 10/21, 1941 had been fine up to that date.**
4. **F. K., cabinet maker, white, 42 years. Allergic rhinitis for 5 years, worse last 2 years, all year 'round. Previous tests: positive for vegetables, tobacco. 8% eosinophiles in blood. Treated 6/16-7/1, 1941. Improved after 3rd injection, symptomless when discharged. 8/4, 1941 2% eosinophiles in blood. Was without complaints during ragweed season 1941, although in previous years he felt worse during this time.**
5. **B. L., white schoolboy, 10 years. Hay fever for 5 years from middle of August till frost. Previous tests also positive to horse hair, orange juice, pig meat. 1939 specific injections without relief. Complaints since 8/24, 1941. Treated 8/24-9/15, 1941. Improved after second injection. Symptomless on discharge.**
6. **A. M., white college boy, 16 years. Hay fever for 8 years. Previous tests positive for timothy, ragweeds. Former specific treatments with slight relief only. Complaints for about 2 weeks when first seen 9/7, 1941. Felt fine after 1st injection. 1/19, 1942 had been all right since discharge 9/23, 1941.**
7. **T. S., white printer, 44 years. Allergic rhinitis and postnasal drip since March, 1941. Typical nasal findings, deviated septum. 9% eosinophiles in blood. Treated 7/7-8/12, 1941. Improvement after first injection, discharged symptomless. 8/12, 1941: 1% eosinophiles in blood.**
8. **E. T., white female factory worker, 39 years. Since June '40 "head cold." Former tests positive to bacteria. Desensitization without results. Treated 3/25-4/5, 1941. Improved after second injection. When discharged after 9th injection, symptomless.**

References:

1. Elsbach, E. J.: *N.Y.S.J. Med.* 41:1248 (June 15) 1941.
2. Schilkret, H.: *N.Y.S.J. Med.* 42:332 (Feb. 15) 1942.
3. Loveless, M. H., & Baldwin, H. S.: *J.A.M.A.* 118:451 (Feb. 7) 1942.

20 EAST 87TH STREET.

IMPACTED CERUMEN: APPARATUS FOR ITS REMOVAL

Max Unger, M.D.

New York, N. Y.

AN unusual and intractable case of deafness is a challenge and a stimulus to the otologist, often out of all proportion to the frequency with which such cases are seen. An enormous literature may develop about such cases and numerous intricate and costly instruments and procedures may be devised for their treatment. On the other hand, more numerous cases, that by their large numbers engage a considerable portion of the physician's energies, are treated in antiquated

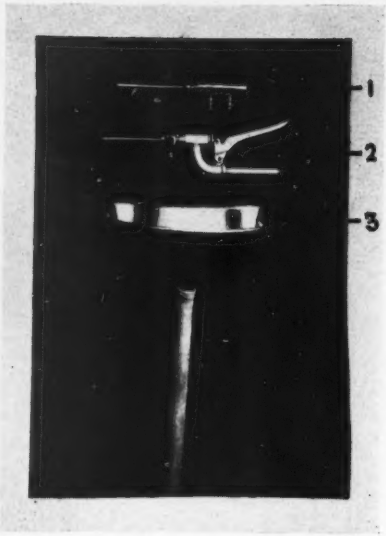

Fig. 1

fashion, with crude instruments and often indifferent success.

Among the latter group are cases of impacted cerumen. The usual procedure in these cases is to attempt to remove the cerumen by irrigating the ear canal with a hand syringe. If this is successful, well and good. Often, however, the wax is so strongly imbedded that the first attempt at syringing is unsuccessful. The doctor may then fill the canal with hydrogen peroxide, have the patient wait a varying length of time, and try syringing again. If not successful this time, he may have the patient return the next day, giving him instructions to instill hydrogen perovide or oil in the ear during the interval, or he may elect to scoop the wax out with an instrument. This procedure is often difficult and painful and may result in abrasions and lacerations of the canal, besides taking an undue length of time.

THE difficulties in removing strongly impacted cerumen are due to a number of factors. First, the ear syringes are hand operated and the physician's hand may not be powerful enough to produce a sufficiently strong stream to dislodge the wax. Second, the metal guard on the syringe for preventing back-splash obstructs the view and the stream is often misdirected. Third, the ordinary ear syringe holds only two ounces and must be refilled frequently in difficult cases. If the piston is tight and the doctor is determined to get the wax out in one session, the end of the session may find him pretty well exhausted. Fourth, the return flow is caught in a pus-basin that the patient or the nurse holds against his face. If he holds it level and steady, there is the trouble of emptying it frequently; if he falters, he gets a bath and the floor a mopping.

In order to overcome the difficulties and unpleasant features attending the removal of impacted cerumen from the ear canal, I have devised the following equipment and procedure.

First, an air-water gun, illustrated by No. 1 in Fig. 1 and by Fig. 2. This apparatus consists of two parts, a removable irrigating tip, that can be taken off by hand for sterilization, and a by-pass valve. The rear end of this by-pass valve receives air from the nozzle of an air compressor and passes it to the short tube of a wash-

Fig. 2

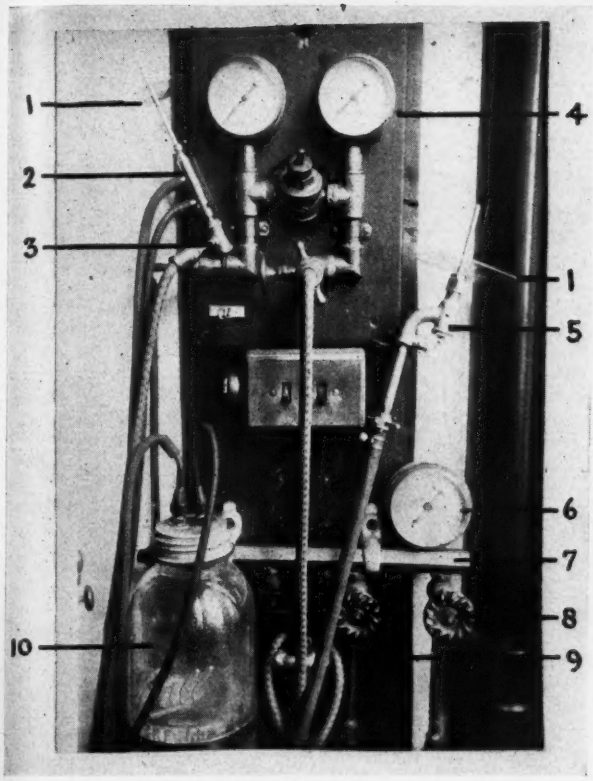

Fig. 3

Parts indicated are: 1. Transparent plastic guards; 2. Air-water gun; 3. Nozzle of air compressor; 4. Air-pressure gauges; 5. Water gun; 6. Water-pressure gauge; 7. Mixer for hot and cold water; 8. Hot water; 9. Cold water; and 10. Wash bottle.

bottle. The front end receives the solution from the long tube of the wash-bottle and passes it into the irrigating tip. The air pressure is maintained at 6-8 lbs. while the stream is flowing. This pressure is enough to remove the most firmly imbedded plug of wax, while at the same time it is harmless to the drum membrane.

THE second instrument devised is a water gun, No. 2 on Fig. 1. This is attached to the hot and cold water faucets of a sink or, better, to permanent outlet valves on the plumbing. The water gun has a detachable nozzle which can be removed for sterilizing and is operated with a lever handle to start and stop the flow of water. Water of the desired temperature is maintained at a constant pressure of 6-8 lbs. while the instrument is discharging.

The third item devised is the draining pus basin shown in No. 3 Fig. 1. This pus basin has a drainage nozzle in its bottom to which a rubber tube is attached. The other end of the tube is led off into the sink. The irrigating fluid can thus drain off into the sink, so eliminating the annoyance of stopping the irrigation to empty the basin and the possibility of spilling the water into the patient's lap. Fig 2 shows a patient holding this basin under his ear.

The fourth item devised is a guard against back - splash made of transparent

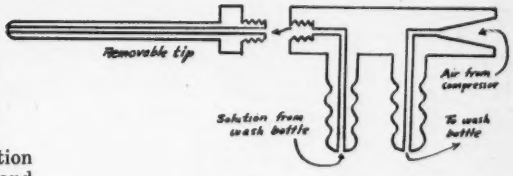

Fig. 4

By-pass valve.

plastic. This is illustrated by No. 1, Fig. 3.

Fig. 3 is a photograph of the permanent installation of these devices in my office. The apparatus described has been of great help. The water gun, especially, shown in No. 2, Fig. 1, is of value in clinics and military induction stations, where large numbers of impacted cerumen cases appear. It cuts the time consumed in re-

moving wax to one-fifth. I have used it with great satisfaction at the New York Induction Station.
36 WEST 40TH STREET.

CULTURAL MEDICINE

THE DEVELOPMENT OF MEDICAL SCIENCE

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New York, N. Y.

THE historical survey is a favorite device to introduce the study of medical science and appreciation of the scope and diversity of past and present accomplishments. No one fact, no one person, has stood alone. Each contributor to knowledge requires the aid and assistance of those preceding him, or contemporary with him. Bacteriology could not become a science until the microscope had been perfected.

The development of medical science is a life work for review alone. To list the names of men contributing to our present state of knowledge or ignorance, according to one's point of view, must needs occupy several hundred pages of index in a medical history of moderate size. It is possible to take one disease, namely syphilis, and sketch the manner of men contributing to its knowledge. We would touch upon superstition. We would enter the revival of learning attendant upon the widespread utilization of the Gutenburg invention of the printing press. We would have to tell of geographical exploration; the advances of bacteriology; of serology and of chemotherapy; of epidemiology. Yet, we would not have satisfied a historian of any of these subjects. Nor would we have given an inkling of the entrance of what we considered to be humanism. Difficult to talk about humanism with the world aflame. Difficult to concentrate on the healing arts and sciences when all efforts are directed to destruction.

In presenting the subject, The Development of Medical Science, we can but offer a few names; names highlighting the transition from magic to what we hope is rational medicine; the rise of science and scientific investigation—another name for controlled studies; the introduction of preventive medicine; and a consideration of the array of workers in the field of medicine, nursing and public health.

The task is made easy by the fact it has been presented to others, for the time came for the city fathers to select the names to be placed on the façade of the building housing the central offices of the Departments of Health, Hospitals and Sanitation at 125 Worth Street, Manhattan. Persons were selected for this signal honor among those having made their mark in the fields of health and hygiene. Complete, although short, biographies of these persons have been published by Dr. Charles F. Bolduan, Director of Health Education of the Department of Health. The title appropriately enough is Illustrious Contributors to Public Health. The booklet is a gem for the collectors' art since it is a limited edition beyond the reach of most. The following notes owe much to this booklet; others are taken from a number of biographical articles I have published in past decades.

IN ancient times, the art and science of what was then understood as medicine was bound indistinguishably with the learned offices of priest, rabbi or exhorter. Medicine was a study based on precedent. The scholar was learned in languages and, if he had access to the books in foreign tongues, soon accumulated much medical lore. Despite this lack of medical teaching, many learned men in those times were prominent for the part they played in medicine and surgery. From the point of view of hygiene, the sister art of medicine and surgery, Moses has an enviable position. Due to the locale and to the ignorance of those surrounding him,

Moses sought by his prohibitions and directions to raise the standard and regimen of living of his coreligionists above that of other inhabitants of their world. In his day the proscriptions were essential, and some of his orders are of value today. It has been claimed that the Jews were free of a number of otherwise common diseases, due to the rules of Moses, and during epidemics of the Middle Ages the Jews were likely to escape.

The institution of the Sabbath as a twenty-four hour recess gave a period of rest to the human mechanism. The utility of this rule has been recognized again, by "big business." Meat inspection, according to Hebrew rites, is observed today in the meat and animal industry. The stamp of approval, "kosher," is imitated at this very moment by the stamp of approval, "Inspected and Passed," of the United States Government, at every slaughter house and point of entry of meat, fish and fowl for human consumption. The disapproval signified by the expression "Trefha" has its counterpart in the "Condemned" meat.

Moses laid emphasis on discharges from the body as vehicles of disease. He had no microscope, remember—no microscope, no conception of bacteria.

WE take a long jump from Moses to Hippocrates. If Moses may be said to be the founder of medicine, Hippocrates is the founder of modern thought in medicine. Born on the Island of Cos in 460 B.C. (he lived until 370 B.C.), Hippocrates sifted the possible from the impossible. He recognized magic and non-magic in medicine. He tried, he observed, he weighed. He had a direct influence on realism in medicine—he opened the way for those following in observance and description. Hippocrates influenced medical thought for centuries. His name is known to all of us as attached to the oath medical men take before entering practice.

We can only mention Galen (130-200 A.D.), the greatest Greek physician after Hippocrates. His name comes to us through the Galenicals. Cold cream is still made according to his formula. Celsus (53 B.C.-7A.D.) was a non-medical person, recorder of the known in medicine, pharmacy, science and what not.

Columbus (1466-1506) influenced medicine by his accidental discovery of the new hemisphere. The theory of pre-Columbian or post-Columbian origin of syphilis is unsettled. Undoubtedly, if Columbus had not made the discovery of the new world, some other explorer would have done so, in fact, many had preceded Columbus, the ill-fated, to these shores. Fracastoro (1483-1553) has the distinction of naming the disease syphilis—the name becoming world-wide. The bibliography on Fracastoro, the editions, translations, etc., requires a book by itself.

Paracelsus (1493-1541), according to legend, took the name because he believed he was superior to Celsus. The original name of Paracelsus was Aureolus Theophrastus Bombastus von Hohenheim. His pet name Bombastus became, according to some legends, a symbol of aggressive self assertion. Another name comes from Paracelsus—quack—because of the mercury he ordered his students to administer they became "quacksilver" medicos, or quack for short.

PARACELSUS has many claims to fame. Among others, he was the first to teach in the vernacular instead of the Latin or Greek of other professors. His experiments and his mysticism led Paracelsus to lay great stress upon the pharmacological value of the metallic salts, particularly those of lead, mercury, iron, antimony, copper, sulfur, and arsenic. He administered mercury internally for syphilis of both the acquired and congenital types. In 1530, Paracelsus gave arsenic for syphilis. He recognized the transmission of syphilis from individual to individual and from parents to child.

We mention Ambroise Paré (1510-1590) at this point because he is rated as the founder of modern surgery, and warfare surgery; also Vesalius (1514-1564) brought anatomy into a modern field. Outstanding is another anatomist—the pan-specialist—the greatest of all humans, the artist, sculptor, engineer, sanitarian humanist, Leonardo da Vinci. His life is worthy of the closest attention.

WILLIAM Harvey (1578-1657), loosely mentioned as the discoverer of the circulation of the blood, really does not deserve the honor. Many before him had guessed at this more or less correctly. Harvey did more than guess. He presented the mathematical and quantitative proof of the circulation of the blood as we know it now, and hence revolutionized medical thought.

Antonj van Leeuwenhoek (1632-1732) was the son of a successful brewer. Until the age of 22, he had been a bookkeeper and cashier of a textile plant. Then he worked as a technician in a laboratory at Delft. He perfected one of the earliest of the compound microscopes in 1675. He was the first to see and describe spermatozoa, red blood cells, and many types of micro-organisms including spirilla. He pictured these. Leeuwenhoek was an exceptional man; he shared his discoveries. He contributed not only literary efforts but his compound microscopes to learned societies, particularly the Royal Society at London.

Recall, please, we are about the date of the Great Plague in London and the great Fire of London, rivalled only by the Blitz of several years ago. How did people live in the London of 1666? What did they look like—how did they go about? What of housing? What of sewage? Of water supply? One way of finding your place in history for this period is to recall the average span of life—some 36 years. A generation, it came to be called. Every one surviving infancy was pockmarked. The Black Death decimated the population every other decade. The working conditions were frightful; human life was held as cheaply as it has not been held again until the Madman of Europe bulldozed the guardians of peace and tranquillity—the appeasers before and after Munich—within our own lifetime!

IT is refreshing to bring to attention Bernardino Ramazzini (1633-1714), founder of industrial hygiene. Ramazzini was physician to Pope, prince, and poor. He was the first to examine critically and in person. He went to study, he stayed to learn, he reserved his opinion until the data were complete. He influenced life after his time. The laws on factory hygiene, on factory inspection, on workmen's compensation, these and others were born with Ramazzini. They were fostered through the ages by the enlightened, and accepted, it seems, by those seeking to inspire others but given pseudo-adherence by some to mislead the non-aggressive world. Hours, conditions, health of the workers have come again to be measured only in terms of production of war goods for destruction. Can any one measure the constructive result of the same energy devoted to the ways of peace? But it is not to be—there must be sacrifice, there must be return to the primitive—let us hope for only a little while—to ensure once more the gifts of labor to the worker . . . and not to the war lords. Perhaps Ramazzini did the world a disservice.

We talk glibly of vitamins and deficiency diseases in this year of 1943. Back in the middle of the eighteenth century, 1754 to be more or less exact, James Lind (1716-1794) wrote a truly remarkable treatise on lemon juice as a preventive and cure of scurvy. He recommended all seamen be given lemon juice as they had been receiving rum—as a daily ration, hence the term 'limey' for an English lad of the sea. Need we go further into the development of vitamins? How much more difficult for Lind to break the ice than for us to go along uncovering deficiency diseases of mice and transferring the lessons to men. Sometimes, truth to tell, with devastating results on both the men and the mice!

IN another direction, Samuel Bard (1742-1821), after whom is named Bard Hall at the College of Physicians and Surgeons, Columbia University, made a remarkable contribution. Physician to George Washington, graduate of Edinburgh in 1765, writer of vivid descriptions of diphtheria and yellow fever, Bard proposed the first public hospital in New York City. His four children died of the yellow fever. So many people did in early New York City . . . not a few physicians, too. In the little cemetery of the Congregation of Spanish and Portuguese Jews lying near Chatham Square, close to Chinatown, is a tombstone to the memory of Dr. Walter J. Judah. Its inscription reads in translation:

Zealous he was in his labors, the labor of healing,
Strengthening himself as a lion, and running swiftly as a hare to bring healing
To the inhabitants of this City, treating them with loving kindness
When they were visited with Yellow Fever.
He gave money from his own purse to buy for them beneficial medicines,
But the good that he did was the cause of his death!

Not only hospitals but jails occupied the attention of public spirited men about this period. John Howard (1726-1790), appointed sheriff of Bedfordshire, England, came to know the conditions of jails all over the European world. He succeeded

in improving conditions for the incarcerated. Jails became a better place to live in, but one wonders whether John Howard foresaw the type of prison opposite the Old Tombs in Lower Manhattan. One wonders if jails should be so much better than hospitals, for example. One wonders if the 17 millions of dollars as once we counted wealth was properly invested in the structure of steel now needed for ships and guns; of the man hours of labor now missed in lack of those very ships.

The insane and feebleminded once held in jails with the mentally well were likewise freed by Philippe Pinel (1745-1826). He removed the bars from the cages of the harmless insane and inaugurated humane care. Yet in my own lifetime, I have seen chained insane in one of our neighboring states. Advances proceed slowly. Degradation goes more swiftly, as witness the concentration camps and forced labor of the ill and weak—among the nations adhering to the New Order!

Edward Jenner (1749-1823) studied the possibilities of immunity against the deadly smallpox. He had observed the innocuous character of cowpox and brought us vaccination (from *vacca*, cow). Only in benighted and befuddled parts of the civilized world—parts of California, for example, is there any endemic smallpox. Vaccination has made living in large cities safe; it makes concentration of soldiers safe, too; that is, safe from smallpox. But the mighty typhus rages, carried by the petty louse. So has the lowest of these—the parasitic body louse—his revenge upon man, his host.

William Farr (1807-1883), not a medical man, introduced the science of vital statistics. The numerology of health—of births—of deaths—is the most important function of a health department in any community, civilized or not. Figures, records, vital statistics are highly regarded and needed. Experts chart the prevalence of contagious diseases; foretell epidemics. We count noses, and count running noses, through the science of vital statistics.

Yet were it not for one or more imaginative persons, physicians unwilling to stay in the realm of darkness, personalities willing to risk reputation, yea, life itself on conviction, there would be small need for vital statistics. Ignaz Philipp Semmelweis (1818-1865) did the work making it possible to say 'index of death of women in childbirth, from puerperal fever, has become an index of civilization.' Semmelweis noted the incidence (there is vital statistics again) of deaths from postpartum fever in a ward attended by medical students and the freedom of deaths from puerperal fever in the neighboring ward attended by midwives. He reasoned, he observed. He noted the students examined the recently delivered women with hands fresh from the study of postmortem pathology; the midwives were forbidden examinations. Did the world of science, did the medical scientists believe Semmelweis? They did not. He besought specialists throughout the world to force the examiners to wash their hands before palpating the cervix. Did the professors of obstetrics order it done? They did not. Semmelweis retired from the university, he stopped practice. He became a letter writer, a pamphleteer. He died, some say insane. The world long after erected a statue to his memory. Women everywhere live and thrive because of Semmelweis. They don't know his name. Perhaps his statue has been fed to the flames to be converted into bullets to destroy the very lives Semmelweis had helped preserve. The American poet Holmes might have done the work of Semmelweis; he wrote an essay on childbed fever. But he was more busy as a poet than as a physician.

How we skip and jump in this survey of the development of medical science From numerology to childbed fever. And now to the operating room. William Morton (1819-1868), despite arguments and controversies, claims and counterclaims, was the first to propose a successful demonstration of the availability of chemical anesthesia during a surgical operation. It was in 1846. Others had utilized anesthesia prior to Morton, but Long in Georgia and Wells the dentist in Hartford had no such influence on the introduction of general anesthesia as had Morton.

From the individual we go back to the general problem of public health and consider Lemuel Shattuck (1793-1859). His reports on public health in 1850 awakened a public consciousness and advanced the science of public health as a community problem. Administration became of age through Shattuck.

And now in the middle of the nineteenth century we come to the one woman of our

story, of our history. Florence Nightingale (1820-1910), in an age before germs and germ theories, instituted kitchen cleanliness into the pestholes of the Crimean Peninsular war in 1850. She revolutionized medical art and science. She was a true humanist. The feminine movement—the one prior to the three K's—Kuche, Kinder, and Kirche—kitchen, children, and church—owes much to Florence Nightingale. Her life has been the subject of too many essays to require further detail here.

A man, a mere man, J. Marion Sims (1813-1883), successfully operated upon women otherwise doomed to a life of suffering and humiliation when he effected the closure of vesicovaginal fistula. Sims founded the Woman's Hospital in New York City. A grateful city stored his statue in a sanitation dump until it was recognized and rescued by an eminent radiologist. The statue now stands on Fifth Avenue opposite the Academy of Medicine.

Another man, Stephen Smith (1823-1922), played a vital part in the activities of the New York Health Department to clean the city, removing pigsties, prohibiting goats and other live stock roaming the streets, leading to a cleaner and in time to a healthier city. Sanitation remains one of the oldest bureaus in the modern health department.

The care of the ill was advanced in one respect due to experience gained in the Civil War. Edward B. Dalton (1834-1872) initiated the ambulance service in New York City after the Civil War. Dalton had been a general in the Civil War, and when he became Sanitary Superintendent of the New York City Department of Health he inaugurated the transfer of the ill by an organized service. The needs of another war maintains the ambulance service with non-medical attendants—an orderly or male nurse now rides the 'bus' and will compete with rescue squads of the fire department and the emergency squads of the police department. Judging from newspaper accounts, members of either branch seem to be very successful obstetricians.

We have the hospital, we have the ambulance to take the patient, we have anesthesia. We once upon a time had laudable pus. It was laudable in contradistinction to fever and disease without pus following operation. It was a sign of hope to have laudable pus. And Joseph Lister (1827-1912), following the work of Pasteur in announcing germs as the cause of some diseases, contrived a spray of carbolic acid in operating rooms. Laudable pus and other pus ceased in that day of antisepsis and it was on the basis of the work of Lord Lister that we arrived in time to asepsis. Surgery was made safe. Semmelweis was dead—but his spirit was soothed.

Who was this Pasteur we have mentioned as the inspiration of the work of Lister? Some medical scientist? No. A humble student of the diseases of wine, of the ills of silkworm, of the cause of anthrax, of the prevention of rabies: these are his marks of distinction. Louis Pasteur (1822-1895) influenced the development of medical science. He founded bacteriology, one might say. He inspired the next name on our list.

Robert Koch (1834-1910) seemed no great figure in science. He was a simple country practitioner. His wife provided him with a microscope on his wedding anniversary, permitting him to carry his studies to fruition in a small country town. Koch discovered the tubercle bacillus in 1882. He proceeded in his studies to announce the Koch pustulates; he revolutioned medical thought, and brought it from the magic of Moses and Hippocrates to a sounder foundation than it had rested upon until his time.

Emil von Behring (1854-1917) deserves a place in our memory book. He discovered diphtheria antitoxin; he made it possible to dispense with the incubators of O'Dwyer. One no longer fears croup—the deadly throat distemper. Yet, von Behring's name is sounded less in one full year than that of an inventor of a machine gun in a day!

We enter the twentieth century. We speak of people our fathers and mothers might have known when we bring you Walter Reed (1851-1902). The army hospital in Washington is named after him. His great exploit consisted in giving a practical demonstration of the epidemiology of yellow fever. His work made the undertaking of the Panama Canal feasible.

William C. Gorgas (1854-1920) was the sanitary engineer of the Panama Canal. He cleared the working spaces of the dreaded yellow fever mosquito. The completion of the Canal placed the United States in the vanguard of naval nations.

With the advent of the Canal, old timers, desk admirals and theorists felt the United States was supreme on all the oceans. The width of the Panama Canal restricted the size of warships; they had to be built to pass. This led, no doubt, to the limitation of naval armaments; to the destruction of war vessels built and building during the decades of our lush prosperity. It led to the kind of thinking destructive to William Mitchell; it led to all kinds of things. It led to "Remember Pearl Harbor." The study of the development of medical science cannot be divorced from life; from the recital of the happenings on the planet. The interrelationship of medical science and the world about it can be no better illustrated than by a résumé of the very few names responsible for the great advance in chemotherapy inaugurated by that genius and inspiration to humanitarians—Paul Ehrlich (1854-1915). Paul Ehrlich discovered 606 or salvarsan, now known by the generic term of arsphenamine. Yet Ehrlich could not have undertaken his studies had it not been for the dye studies of another youth, the English chemist William Perkin. The youthful English boy was led to his happy discovery leading to the wonders of the coal-tar barrel through the chemistry of Hoffman; influenced in his turn by Kekule, architect of atoms. The side-chain theory of Ehrlich may be all wrong, but it led to the Wassermann reaction for syphilis. The dye chemistry of Ehrlich, his chemotherapy, led in turn to the sulfa compounds, themselves revolutionary in medicine.

WE are up to the minute—or nearly so. Today may find some new discovery in the printing shop of a medical journal leading to completely revised ideas of the development of medical science. A new vaccine; a new toxin; a new procedure may revolutionize life. We anticipate new things to destroy life—why not to maintain it!

Our time and space are used up—we have not mentioned the development of the physics of medicine. No word of Helmholtz, the mathematician inventor of the ophthalmoscope. Not a line regarding Gilbert the Physician to Queen Elizabeth, namer of electricity. No hint of Becquerel, who inspired the Curies; nor of Crooks, accidental discoverer of the x-ray; nor of Roentgen, first to trace the invisible rays clouding his plates hidden in a closed cabinet. Each of these and many more made world-amazing statements—each of these created something vital in medicine.

Please note the entrance into this brief summary of the development of medical science of non-medical scientists—social scientists, one might say, describes them.

It would seem man on earth had hoped to survive in his battle against the host of his enemies in the zone of micro-organisms, of bacteria. We had only to fear degenerative diseases; cancer the unknown; heart and vascular faults; and mental failure. But man forgot man's inhumanity to man. Man forgot man as his bitterest enemy. Man may yet exterminate man.

18 East 89th Street.

War-Time Child Care

WITH communities throughout the country mobilized to meet war-time child care needs, and nearly 100,000 children provided for in Federally aided child care centers alone, the program to help women in jobs is making a major contribution to the war effort, the Office of War Information reports. In approximately 1,000 communities and in every state, Child Care Committees have been organized. In settlement houses, public schools, churches and community centers, groups of children are now spending the hours of day or night in which their mothers work on assembly lines or at the many civilian jobs where women are replacing men. Communities recognizing child care as a problem of great importance have pooled their resources, extended the services of the education, welfare and health departments to cope with the problems that are growing out of the industrialization of women. In some cities the need for child-care services developed gradually so that intelligent planning ahead was possible; in others, like San Diego, Calif., the situation became acute, swamping community facilities almost overnight.

MEDICAL SOCIOLOGY

Should Marriage Wait? The Soldiers' Viewpoints

Frederick L. Patry, M.D., Albany, N. Y.

THE November, 1942 issue of the *Woman's Home Companion* contained a provocative article: "Should Marriage Wait Until After the War?" By two to one this magazine's 2000 Reader-Reporters say "No!". This, however, is from the point of view of *women*. It is not only interesting but fair to inquire what men entering the army think of the marriage question.

In the summer of 1942 the writer had an opportunity of asking 131 selectees at the Albany Induction Station this question: *"Ought one to marry before joining the army or should one wait until after the war?"* The replies were in marked contrast to those of the Reader-Reporters referred to above. Apparently the masculine psychology of marriage differs in bold contrast from that of the feminine mental house-furnishings. The motives and reasons for this discrepancy deserve unbiased inquiry.

In the series of 131 men then about to be sworn into the armed service we find an age-range of 19-45 years; average age of 30. 82 per cent were single, 10 per cent married, 4 per cent separated, 3 per cent divorced and 2 per cent widowed. The average weekly salary was $30 per week. The average educational achievement was first year high school.

No attempt was made to interrogate any particular age-group or those having a special educational, occupational, income or civil status. It was a random sampling; each man was asked the same question as he happened to appear in turn at this neuropsychiatrist's desk for examination.

Statements in such a setting are frank and unvarnished. The situation uniquely lends itself to obtaining the naked truth. There is no point in coloring one's thoughts to an impartial and unknown physician. People in general talk most candidly to physicians and likewise men undergoing a very critical life experience of induction into the army are invariably sober in judgment, honest in statement and candidly—almost naively—frank.

Although this random sampling is small in number, the writer feels that it is quite representative of the men inducted, at least in this part of the country. Especially is this opinion justified when we find such an overwhelming majority of men in favor of deferring marriage until after the war.

NOW for the upshots. *In favor of postponing marriage till after the war?* The response was overwhelming. One-hundred and eleven or 85 per cent thought marriage should be deferred; thirteen or 10 per cent were *undecided;* and seven or 5 per cent were *in favor* of marriage before joining the army.

In contrast to these "cold facts" we note that the response of the 2000 Reader-Reporters to the question: *"Is it right or wrong for men in the armed forces to marry?"* was: 63 per cent think it *right,* 30 per cent think it *wrong* and 7 per cent *don't know.* In other words, the divergency views of the sexes are: *women* it's 2 to 1 it's *right;* men it's 17 to 1 it's wrong or at least *unwise.* So far as the men are concerned Cupid fails to triumph over Mars or rather the effect Mars has on men's discriminatory cerebral functioning.

Although there is no marked divergencies between the responses of the three groups: (1) "In favor of postponing marriage"; (2) "Undecided"; and (3) "In favor of marriage" we find several significant tendencies. The average age of the men "in favor of postponing marriage" was 30 years in contrast to the age of 27 years for the "undecided" and 32 years for the "in favor of marriage" group. This might indicate that the younger the group the more undecided it is whereas the older the group becomes the more in favor it is of marriage before joining the army. It is notable that the salary per week of the group in favor of marriage was $35 in contrast to $30 for the other two groups. This may point to a greater readiness for marriage on the part of those who are more financially secure. On the other hand the average educational achievement of

the group in favor of postponing marriage was first year high whereas it was second year high school for the other two groups. This may be related to the desire for greater educational achievement and especially before taking the "final plunge."

THE data concerning civil status is suggestive of certain tendencies. Of the group "in favor of postponing marriage" we find that 7 per cent were married, 77 per cent single, 5 per cent separated, 3 per cent divorced, 2 per cent widowed and by way of an oversight 6 per cent were not asked. This stands in contrast to the "undecided" group wherein we find 15 per cent married and 85 per cent single. Of those "in favor of marriage" we find 28 per cent were married, 43 per cent single, 14 per cent divorced and by way of oversight 14 per cent were not asked. It is interesting to note that 28 per cent of those "in favor of marriage" were married in contrast to only 7 per cent of those "in favor of postponing marriage." Fear of the unknown and hesitancy in taking the final step are characteristic of the unmarried group. It is significant that we find a ratio of 4 to 1 in the married group who are "in favor of marriage" before joining the army to those "in favor of postponing marriage." It is also remarkable that almost 2 to 1 of the single group are either "in favor of postponing marriage" or are "undecided" in contrast to those who are in favor of marriage before joining the army. 5 per cent of those who are separated were in favor of postponing marriage as well as 2 per cent of the widowed. It is worthy of note that 14 per cent of those divorced were in favor of marriage before joining the army. This stands in contrast to the 3 per cent divorced who were "in favor of postponing marriage" until after the war. Apparently the marital objective is not significantly dampened by divorce experience. On the other hand, 2 per cent of those widowed were in favor of postponing marriage until after the war.

Let us now look at a tabulation of the reasons why these men thought that they should wait (or not wait) till after the war before marrying.

Table I

Reasons why one should wait until after the war to marry:

1. Possibility of leaving dependents	18—16%
2. May come back injured	14—13%
3. No particular reason	10— 9%
4. Possibility of getting killed	9— 8%
5. Not sure what the future is going to be like	7— 6%
6. Might change your mind	6— 5%
7. Couldn't support wife	6— 5%
8. Wouldn't want to leave wife behind	6— 5%
9. Too many hardships	6— 5%
10. Wouldn't want to tie a girl down	6— 5%
11. More security after war	4— 4%
12. No worries	4— 4%
13. Less responsibility	4— 4%
14. More important to win war	3— 3%
15. May marry to get out of army	2— 2%
16. Couldn't make home	2— 2%
17. Good test of girl's affection	2— 2%
18. Fairer	1— 1%
19. Better for mother and father	1— 1%

Table II

Reasons why one shouldn't wait until after the war:

1. It's all right to marry now if one wants to	3—43%
2. It's all right if sufficiently in love	2—28%
3. Better outlook on life	1—14%
4. Be more satisfied	1—14%

OF course, marriage is of vital importance to the average adult, especially to the age group of 19 to 45 years encompassed in this study. But it is apparen that the men are decidedly more intellectual in their approach to this momentous step than women, at least while the men weigh the marital situation from the viewpoint of the threshhold of becoming one of Uncle Sam's soldiers. The writer does not wish to infer, however, that the 2000 Reader-Reporters mentioned in the November article are predominantly emotional or impulsive in their judgments or opinions. They see through different pairs of eyes. The perspective of the women interrogated, by and large, laid less emphasis on the long-range perspective than the men. The "Don't miss it" reaction was in the ascendancy. Apparently women's instinctive-emotional drive concerning marriage and procreation comes more to the front in a war crisis than it does in men.

WHAT are some of the facts and factors entering into these men's opinions and reasons for deferring or embracing marriage, or giving rise to constructive doubt in a situation where there are so many unknown and unpredictable elements? Here are a few representative responses relative to the three groups discussed above when presented with the question, *"Ought one to marry before joining the army or should one wait until after the war?"*

(Age group indicated by asterisks: *19-

24 years, **25-34 years, ***35-45 years).

I don't know. It's up to the individual. I'd marry before but there are no likely subjects. I haven't looked around. I have other interests, my art.***

At times I think I should, at other times I think I shouldn't. I don't think it's wise because I might not come back. If I do return I might be disabled or things might be tough in getting along.**

It's all the way you feel about it. If you want to, O. K. I don't want to get married. I know some who were married, were unhappy, divorced. I'll just be an old bachelor.***

It all depends on how much he cares for the girl.**

I don't intend to get married. I had a sister die and leave two children. Any money I get I'll send home for the kids.**

I'm not for or against. It's best to wait. If anything should happen to you your wife and maybe children are left behind.*

It's up to the individual. Each man should be the master of his own destiny.***

It's all right under certain conditions. OK if you have a good home. If the home environment isn't good the woman will go in the street.***

It's best to marry before and have children. One shouldn't marry to escape service in the army.**

I did. It gives you a better outlook. The emotional side enters into it. You find some happiness before you go away.**

Might as well be married before as after.**

Wait! We have a job to do.***

Wait until after the war. One is not sure of getting back.*

Let us go and let us come back. If you want a wife then, OK. No use making hardships. No use having fatherless children.***

Why leave a widow? Besides, she may not think the same of you on coming back.***

Wait. I was in the army for four years and made the mistake of marrying in service. A man is better off single. I have a boy in service and I'm trying to talk him out of it.***

Wait. However, in my case there was a child that wasn't planned for. I neglected to get married until two weeks ago, otherwise I'd wait. Why leave anyone grieving?***

Wait until after the war. Why take a chance of being killed or maimed. Could mean a large responsibility if there be children. If you wait until after the war you know what you're doing. The average person will marry after the war.*

Wait. It is not satisfactory from the married standpoint and besides, time may change many things.**

Wait. My girl isn't through college yet. I couldn't support her now.**

After, by all means. I don't think a man is prepared to marry under these conditions. Matrimonial obligations are too great.**

Wait. It is more important to win the war than take on new responsibilities.***

Wait. I see no sense in marrying now. Liable not to come back. Might leave a wife and child. It wouldn't be fair.**

Wait. Might not come back. If you do, you might be a total cripple and besides have children to support. Your wife might run around with another fellow. There will be a lot of women to pick from after the war. Many women marry for insurance.***

Wait. When you marry you are supposed to be home.***

Wait. You might get a leg shot off and not be so good a husband.**

Wait. It's unfair to the woman. If you get killed it would spoil her opportunities.**

Wait. I'm engaged, but it is asking too much. A child may be born while I'm gone.*

Wait. I don't know if I'm going to come back. The girl ain't going to stay alone all the time.**

Wait, in 90 per cent of the cases. Marriage is made on an emotional basis such as war hysteria. Cannot think on straight lines. Marriage is an emotional rather than a logical contract. The girl marries a uniform.***

Wait. Fight for your country better because there is less worry on your mind.*

Wait. You may not come back. You can have a little happiness but if the girl cares for you she'll wait until you come back. It's a good test for both.*

Wait. I'd like to have some money saved up first.*

Wait. May come back crippled and be on the girl's hands and spoil her life.**

I'm never going to marry. I don't care for it—as I've seen it. It's OK if you get the right one. Best to wait until after the war as you might leave dependents.***

Summary and Conclusions

1. Men joining the army view the marriage question in a radically different way from women.
2. Although the present series is small in comparison to that of the *Woman's Home Companion* survey, 131 to 2000, we find a striking contrast in the different sex responses. In the former study there is a 17 to 1 ratio to defer marriage; in the latter survey there is a 2 to 1 ratio in favor of marriage.
3. There are certain *suggestive tendencies* noted in the responses: 85 per cent defer; 10 per cent undecided, and 5 per cent favor marriage.
   (1) The younger the men the more undecided they are; the older they are the more they are in favor of marriage before joining the army.
   (2) The salary of those who are in favor of marriage is greater than those who are undecided or who wish to defer marriage.
   (3) The educational achievement of those postponing marriage is lower than is the case in the other two groups.
   (4) Those with marital and divorce experience favor marriage before joining the army more than do single men. Divorce does not dampen marital ardor.
4. Two tables enumerate group responses relative to reasons for or against postponing marriage.
5. Men appear to be more *intellectual* in their approach to marriage than women in war time. The emotional-instinctive urge comes more to the front in women. In men we observe the more discriminatory long-range evaluation of facts and factors playing a motivating role. Mars stirs the head of men, the heart of women. Winning the war to men is more influential than procreating the race and its part-steps, romance and marriage.

218 State Street.

CONTEMPORARY PROGRESS

GYNECOLOGY

The Management of the Retained Cervical Stump

C. H. TYRONE and J. C. WEED (*American Journal of Surgery*, 59:473, March 1943) report 44 cases in which symptoms referable to the retained cervical stump persisted after subtotal hysterectomy. All of these patients had excessive vaginal discharge, which was bloody in 14 instances; pelvic pain, dysuria and backache were noted alone or in combination in 20 cases; and 9 patients complained of dyspareunia. In all these cases symptoms were due to a chronic cervicitis. Conservative treatment may be tried before radical procedures are attempted in such cases. This includes dilatation and office cauterization, but cauterization is indicated only for erosion or eversion, without extensive cervical hypertrophy and cystic changes. The authors note that some gynecologists advocate deep cauterization of the cervix at the time of subtotal hysterectomy; they are of the opinion, however, that while this procedure may "impede the development of malignancy," it does not necessarily overcome chronic cervical infection, and that extensive cauterization is "undesirable" because it predisposes to stenosis of the cervix with retention of cervical secretions. If nonoperative treatment of cervicitis is unsuccessful, or if there is hypertrophy, stenosis or bleeding, removal of the cervical stump is necessary. This operation was done in 39 of the 44 cases in this series; in 2 cases early malignant changes were found in the cervical stump after removal. The authors are of the opinion that in every case in which hysterectomy is contemplated, the cervix and vagina should be carefully inspected. If cervical infection is found, a total hysterectomy should be done unless the patient's general condition contraindicates this operation. If a subtotal hysterectomy is done in such cases, the patient should be directed to return within a year for removal of the cervical stump. The operation for removal of the cervical stump is "a technically easy operation to perform," and involves no more risk than any plastic operation on the vagina.

COMMENT

Here again appears the everlasting question of supracervical versus panhysterectomy. It will never be settled. We believe that "other things being equal" and with a bad cervix panhysterectomy is preferable. It gets rid of the troublesome cervix. On the other hand, certain cases call for supracervical amputation of the uterus solely for the sake of safety. In such cases we always "core out" the endocervix with the cautery immediately preceding supracervical hysterectomy. In several hundred such "core cauterizations" we have seen no cancer or other troublesome pathology develop in the atrophied shell of the remaining cervix. Certainly leaving the "untouched" cervix routinely amounts to inadequate surgery and therefore is pernicious practice. ***H.B.M.***

Intracyclic Bleeding

R. B. GREENBLATT (*American Journal of Obstetrics and Gynecology*, 45:299, Feb. 1943) notes that the periodic occurrence of bleeding in the mid-menstrual period is probably "an atavistic feature," similar to ovulation bleeding in the monkey. As a rule this "ovulation" bleeding is minimal and causes the patient no discomfort; but it may be prolonged and copious and require treatment. In all cases such conditions as submucous fibroids, endometrial polyps, or malignancy must be ruled out as a cause of the bleeding. If cyclic hypermenorrhea is complicated by profuse intermenstrual bleeding the patient may be "physically, as well as psychically, upset." In 6 patients in whom intermenstrual bleeding required treatment, it was found that testosterone propionate in dose of 10 to 25 mg. at weekly intervals during the intermenstruum alleviated the syndrome. Methyl testosterone given by mouth in doses of 5 to 10 mg. daily during the intermenstruum was equally effective in arresting the bleeding and pain and did not interfere with ovulation. The menstrual cycle can usually be stabilized by continuing treatment for several months during the intermenstrual period. One patient who had been sterile became pregnant several months after the menses had been stabilized and treatment stopped.

COMMENT

The old aphorism "what's good for the gander is good for the goose" apparently works in intracyclic uterine bleeding. The administration of androgens for the amelioration of various menstrual disorders is well established. The author was successful in controlling midmenstrual bleeding in 6 patients by the use of either testosterone propionate or methyl testosterone. There seemed to be no difference in the efficacy of these preparations. Try it on your next case! H.B.M.

The Effect of Preoperative Irradiation on Adenocarcinoma of the Uterus

H. E. SCHMITZ, J. F. SHEEHAN and JANET TOWNE (*American Journal of Obstetrics and Gynecology*, 45:377, March 1943) describe their technique for radiation therapy of carcinoma of the uterine fundus. A Y shaped radium filter is employed which contains 50 mg. of radium element; this is inserted into the uterine cavity. Three treatments of 2000 mg. hours each are given at eight day intervals. Radium therapy is combined with x-ray therapy, with 800 kilovolt maximum; two or more fields are used and the dose is calculated to deliver 4000 roentgens within the pelvis in twenty-eight days. The x-ray treatments are given on days when the radium is not in the uterus. In 11 cases hysterectomy was done after irradiation therapy; in 5 cases in which the full course of treatment was given, no carcinoma was found in the uterus, and microscopic study of serial blocks of the uterine wall in 4 of these cases failed to show residual carcinoma. Iu 6 cases in which the preoperative treatment was inadequate, according to the authors' standard, active carcinoma was present in the uterus. In 27 cases treated by irradiation but not hysterectomized, curettage and follow-up studies indicated that adequate radiation therapy is of definite value in carcinoma of the fundus of clinical groups I and II. The authors do not advocate radiation therapy instead of surgery for patients who are good surgical risks, but they are of the opinion that their plan of preoperative irradiation should be carried out "until sufficient case records are on hand to determine whether the five-year salvage is greater" with this method than with surgery and postoperative irradiation.

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COMMENT

It is conceded that there are "several good ways" of treating fundal cancer. We still do not know the "perfect" method. However, the work of Schmitz and his co-wokrers is most commendable. We cannot agree entirely with the procedure, because it does not include postoperative irradiation. If preoperative irradiation is effective — and certainly this has been proved — then why is not postoperative irradiation indicated? We believe that it is. Who can tell whether or not a few — even one — cancer cells may have escaped both preoperative irradiation and the scalpel and be "caught" by postoperative irradiation. We are convinced that preoperative irradiation, plus operation, is far superior to operation alone. Furthermore, we have found that the addition of postoperative irradiation gives better 5-year results. Any successful treatment depends on early diagnosis. The family doctor is the "key" man in the cancer problem. He should cultivate a "malignancy consciousness." H.B.M.

Sulfanilamide and Sulfathiazole Therapy in Acute Salpingitis

D. N. BARROWS and J. S. LARATE (*American Journal of Obstetrics and Gynecology*, 45:82, Jan. 1943) report a

study of 204 cases of acute adnexal disease. Sulfanilamide or sulfathiazole was used in the treatment of all cases in which the urethral and cervical smears were positive for gonococci; palliative treatment was employed in some of the cases in which smears were negative, in order to obtain a control group. In 71 of the cases in this series, the acute disease was primary, in 133 recurrent. Both sulfonamides were given in the following dosage: 1 gm. four times daily for two days; 1 gm. three times daily for the next three days; and 1 gm. twice daily for the last two days—a total of 21 gm. in a week. If the smears of urethra and cervix failed to become negative after this course of treatment, a second course of treatment was given in a succeeding week; in a few cases if the patient failed to respond to treatment with one of the sulfonamides during the second course of treatment, the other sulfonamide was substituted for it. The best results with this method of treatment were obtained in primary acute adnexal disease of less than five days' duration; complete resolution of the adnexal masses was obtained in 70 per cent of these cases after one week of treatment with either sulfanilamide or sulfathiazole; only 20 per cent of the control group treated by palliative measures alone showed complete resolution of the adnexal masses. The primary acute cases of more than five days' duration showed little if any better response to sulfonamide therapy than to palliative therapy. In the cases of recurrent acute adnexitis of less than five days' duration, sulfonamide therapy resulted in complete resolution of adnexal masses in 52 per cent, as compared with 23 per cent following palliative treatment. In the recurrent cases of longer duration, the response to chemotherapy was not better than to palliative therapy. Toxic reactions with either sulfanilamide or sulfathiazole in the dosage employed were "minimal." Some gastric irritation was noted in 3 per cent of the patients treated, and one patient developed a slight leukopenia which responded well to blood transfusion. While positive cervical and urethral smears became negative in all cases under sulfonamide therapy, the effectiveness of chemotherapy in gonorrheal lesions "above the level of the internal os" evidently depends upon the duration of the adnexal disease before chemotherapy is begun. The authors are of the opinion that permanent tubal damage may be "prevented or minimized" if chemotherapy is begun within five days of onset of a primary attack of adnexal disease.

COMMENT

Chemotherapy has proved its worth in the treatment of gonorrhea below the internal os. The authors have extended its use in acute gonorrhea above the internal os—particularly in acute salpingitis—with excellent results. We can agree entirely with their conclusions. Begin early and give full therapeutic doses. What a boon to the management of gonorrhea in both females and males! *H.B.M.*

The Rational Use of Oral Estrogens in the Menopause

S. J. GLASS and GORDON ROSENBLUM (*Western Journal of Surgery, Obstetrics and Gynecology*, 51:4, Jan. 1943) report the use of the new natural estrogen, premarin, supplemented by minimal roses of diethylstilbestrol. In many women premarin alone, given in one or two tables daily, is sufficient to control the menopausal symptoms. Each tablet of premarin contains approximately 1.25 mg. of active material with a biological potency of about 600 Collip units. In the more severe or acute episodes of the menopause, diethylstilbestrol given by mouth has been found to be "an excellent substitute" for injections of estrogen formerly used in treatment of these more severe symptoms. When these acute or severe symptoms are relieved by the combination of diethylstilbestrol and premarin, the former is "gradually eliminated leaving premarin alone to maintain the estrogenic effects." Of 80 women with menopausal symptoms treated by this method, 69, or 86.3 per cent, showed a good response to this therapy and 7, or 8.7 per cent, showed a "fair" response; the results were poor in only 5 cases. From these results the authors conclude that with "the judicious combination" of the synthetic estrogen diethylstilbestrol, and the natural estrogen premarin, both of which are effective by mouth, routine injections of estrogens can be avoided in the treatment of the menopause. The combined treatment the authors consider to be effective, simple, safe and economical.

COMMENT

Some women do not need estrogen therapy during the menopause; many others do. The

vast majority of those who need this therapy can take it orally and derive full benefit. Hypodermic injection is seldom necessary. We have had excellent results with premarin and/or stilbestrol by mouth. *H.B.M.*

OBSTETRICS

A Ten-Year Analysis of Puerperal Sepsis Deaths

C. C. BRISCOE (*American Journal of Obstetrics and Gynecology*, 45:144, Jan. 1943) presents an analysis of 308 deaths from puerperal sepsis occurring in Philadelphia during the past ten years. Deaths from puerperal sepsis occurred most frequently in women thirty-five to forty years of age; septic deaths occurred in a higher percentage of primiparas than of multiparas. Four women died undelivered; delivery was spontaneous in 40.2 per cent of these fatal cases of sepsis, and operative in 57.2 per cent; 33.1 per cent of these deaths followed cesarean section. Fatal infections followed hospital delivery in 246 cases, and home delivery in 58 cases; the 4 patients who were not delivered died in the hospital. The septic death rate per 1000 total births was somewhat greater for home deliveries (1.15) than for hospital deliveries (1.0); but the hospital "must bear the burden" of delayed admissions, toxic and hemorrhagic cases and other complicated cases, in which operative interference in the home has increased the danger of sepsis. An analysis of these fatal cases of puerperal sepsis by the Committee on Maternal Welfare of the Philadelphia County Medical Society classifies 230 of the 308 cases as "preventable." The error was attributed to the patient in 24 cases, but to the physician in 206 cases. On the basis of this analysis, the author concludes that the causes of puerperal sepsis vary "from violation of elementary principles, through fine errors of judgment and technique, to unavoidable disaster."

COMMENT

By such studies as this, from many parts of the United States, we have finally "driven home" to the physician and many lay organizations why our maternal mortality rates remained static for over 50 years. Every County Medical Society should have a Maternal Welfare Committee headed by a Chairman who "does things" and by this means improve its maternal and fetal mortality rates. This is "preventive medicine" of the highest order. Philadelphia has shown the way! *H.B.M.*

Plasma Vitamin C and Prothrombin Concentration in Pregnancy and in Threatened Spontaneous, and Habitual Abortion

C. T. JAVERT and H. J. STANDEL (*Surgery, Gynecology and Obstetrics*, 76: 115, Jan. 1943) report that bleeding occurred in the first trimester of pregnancy in 2209 patients or 9 per cent of the total number of pregnant patients studied at the New York Hospital from Sept. 1, 1932 to Dec. 31, 1940. In most of these cases the bleeding was associated with complete, incomplete or threatened abortion. In a study of the vitamin C and K of the blood plasma in pregnant women, it was found that in normal pregnancy the vitamin C content decreases from 1.1 mg. to 0.35 to 0.4 mg. per cent at term; but the plasma prothrombin normally shows little reduction during pregnancy. In 79 patients with threatened, spontaneous, or habitual abortion, deficiency in vitamin C was found in 69 per cent, deficiency in vitamin K in 72 per cent, and deficiency of both vitamins in 61 per cent. Treatment has been instituted in some cases with a diet high in vitamins C and K, as well as adequate in other vitamins, including the administration of cevitamic acid and synthetic vitamin K in cases in which the plasma concentration of these vitamins was very low; in addition a mineral supplement has been used, in some cases vitamin E, and in some cases of threatened abortion, progesterone. This treatment has been employed in 33 cases of threatened abortion, one or two previous abortions, and habitual abortion (three or more consecutive abortions). The incidence of abortion in these cases was 20 per cent in the cases of threatened abortion and 7 per cent in the cases of habitual abortion, while none of the patients with one or two previous abortions aborted under treatment. In control cases in each group, the incidence of abortion was 100 per cent. Of the 33 patients treated, 24 out of the 25 delivered have had living children.

COMMENT

It has been fairly well established that deficiencies in vitamin C, D and E or all three are often associated with the pregnant state.

This is particularly true in the abortion cases. The authors very properly used this information as a criterion for therapy. They obtained very good results by the administration of vitamins C, D, K and E in all bleedings of early pregnancy and progesterone in certain cases of threatened abortion.

We recommend a thorough digestion of this paper—particularly that part pertaining to abortions. There is something in the idea! *H.B.M.*

Demerol and Scopolamine in Labor

CHARLES ROBY and W. R. SCHUMANN (*American Journal of Obstetrics*, 45:318, Feb. 1943) report the use of demerol and scopolamine in 112 consecutive deliveries. Demerol is one of the recently developed analgesics; chemically it is 1-methyl -4-phenylpiperidine -4-carbonic acid ethyl ester; it possesses both atropine-like and morphine-like effects, including a spasmolytic action on smooth muscle with "a slight sedative and marked analgesic effect." In the usual therapeutic doses it has little effect on respiration, and for this reason it was used in combination with scopolamine as an analgesic in labor. As soon as the patient began to complain of pain, she was given 100 mg. demerol by intramuscular injection, and 1/100 grain of scopolamine subcutaneously, then 1/200 grain scopolamine an hour later. This was usually sufficient to give relief to multiparas throughout labor, but in primiparas additional doses of scopolamine 1/200 grain were given every one to five hours. With this medication amnesia was good in 95 cases and poor in 17 cases; the average length of labor in primiparas was twelve hours two minutes and in multiparas eight hours and forty-six minutes. The infant was "active" and in good condition in 96 cases. The condition of the patients delivered under demerol and scopolamine analgesia "was, in general, favorable"; vomiting and other undersirable by effects occurred no more frequently than with other types of medication. The majority of patients were "conscious enough to be cooperative," and restlessness was "minimum" because of the infrequent administration of scopolamine. The absence of "serious respiratory depression" in the infants makes this type of analgesia especially desirable for obstetric use.

COMMENT

There is no ideal method for the alleviation of "labor pains." There are many methods in use today which are more or less satisfactory for the mother but less so for the baby. Demerol and scopolamine is one of the most recently "discovered" methods. We have had no personal experience with demerol but, judging from several reliable reports, it is superior to morphine in many respects, particularly as regards safety to the baby. If morphine should become "rationed" or unobtainable, we would not hesitate to use demerol as a substitute. "Necessity is the mother of invention" might again be proved. *H.B.M.*

Resume of Cardiac Disease in Pregnancy For a Five-Year Period

T. R. TURINO and J. T. WALLACE (*American Journal of Obstetrics and Gynecology*, 45:526, March 1943) report a study of 102 women with chronic cardiac disease who when pregnant were cared for in the Obstetrical Department of the Brooklyn Hospital in 1937 to 1941. During this period there were a total of 5,664 deliveries. There were three therapeutic interruptions of pregnancy in the first trimester; 96 patients were delivered from below, usually by low forceps to shorten the second stage; and 7 by cesarean section. Two of the latter were "repeat sections." There was one death in this series, following cesarean section and due to pneumonia. The authors note two general trends in the handling of pregnant cardiac patients at the Hospital. First, the tendency to deliver more and more of these patients from below rather than by section; and second, the tendency to use cyclopropane as the anesthetic for vaginal deliveries instead of open drop ether, and to use local anesthesia for cesarean sections. The most unusual case in this series was one of coarctation of the aorta; the patient was seen in the cardiac clinic in the fifth month of pregnancy. The diagnosis of coarctation of the aorta was made on the basis of the clinical findings and a teleroentgenogram of the chest. The patient at that time felt no distress. She was kept under strict supervision and was carried to within three weeks of term without developing any untoward signs or symptoms. An elective cesarean section, supplemented by Pomeroy sterilization, was then done, and a living child delivered. The patient made a good recovery and was discharged from the hospital on the twentieth day after delivery. The authors note that coarctation of the aorta is a rare complication of pregnancy, only 29 cases being reported in literature up to 1940.

Because of the rarity of this condition,

it is of interest to note that C. W. Walker (*British Medical Journal*, 1:190, Feb. 13, 1943) has recently reported a case of pregnancy in a woman with coarctation of the aorta. The diagnosis of congenital coarctation of the aorta had been made when she was twenty years of age; at that time her activity was greatly restricted, but she became stronger and more active. When seen by the author she was in the second month of her first pregnancy and appeared well; she remained well during pregnancy, taking some exercise but being careful to have sufficient rest. Premature labor began five weeks before term; the progress of labor was slow but there was no cardiac distress until the onset of the second stage, when the patient became "acutely distressed and breathless"; she was delivered by forceps of a living child. This patient was allowed to undergo labor, because her condition was good and she had requested it. But the author considers that cesarean section at the onset of labor is the method of choice in these cases. Turino and Wallace, however, advise an elective cesarean shortly before term.

COMMENT

Heart disease complicated by pregnancy remains a serious problem. Neither the cardiologist nor the obstetrician alone can give the patient adequate advice or care. Working together, much can be accomplished. We believe, as the authors state, that the modern tendency is toward conservatism in the advice and management of pregnant cardiacs. A few pregnant cardiacs need cesarean section; most of them do not. When cesarean section is indicated consideration should be given to the basic reason for said indication, i.e., is it obstetric or cardiac or a combination of both —before the proper anesthetic is chosen. Some cases do better with "open drop" ether; others with local. Recently we have used continuous spinal or caudal anesthesia with pleasing results. At delivery, every severe cardiac should have the obstetrician, the cardiologist and the anesthetist present. Until this is done, pregnant cardiacs will not get the service they deserve. No "cardiac" should be delivered at home. ***H.B.M.***

Some Observations on the Use of Nicotinic Acid Amide as an Adjunct in Obstetric Analgesia

J. R. PERDUE (*Southern Medical Journal*, 36:198, March 1943) reports 159 deliveries in which barbiturate-hyoscine narcosis was employed, and nicotinic acid amide was given subcutaneously during labor, often repeated two or three times, especially if unusually heavy sedation was necessary; the usual dose for each injection was 100 mg. As a rule 3 grains of sodium pentobarbital and 1/150 grain of hyoscine were given when labor was established or when the patient requested it; many patients, especially primiparas, were given an additional 1/200 grain of hyoscine and 3 to 4½ grains of sodium pentobarbital during the course of labor. Morphine and other opiates were used infrequently and in small doses. In this series of deliveries the infants breathed spontaneously in 95 per cent of cases. In comparison with previous cases in which barbiturate-hyoscine narcosis was employed, "considerably fewer" infants required resuscitation. It was noted also that there was less maternal restlessness. The nicotinic acid amide did not reduce the percentage of successful analgesia and amnesia, and had no toxic effects.

RHINOLARYNGOLOGY

Evaluation of Privine HCL as a Nasal Vasoconstrictor

N. D. FABRICANT and O. E. VanALYEA (*American Journal of Medical Sciences*, 205:122, Jan. 1943) present a study of Privine HCL as a nasal vasoconstrictor. This drug is one of a new series of imidazolone derivatives recently synthesized; chemically it is a 2-naphthylmethyl imidazoline; it is colorless and easily soluble in water or in saline solution. In a 0.1 per cent solution Privine HCL is isotonic and has a pH of 6.2; studies of the pH of the nasal secretions in normal persons by one of the authors (N.D.F.) has shown this to vary from 5.5 to 6.5. In animal experiments it was found that the 0.1 per cent solution of Privine HCL had no harmful effect on ciliary activity, but rather appeared to act favorably on it. In patients with acute rhinitis, the Privine HCL solution, when instilled into the nose or applied on tampons, was an effective vasoconstrictor; this effect persisted at least as long as, and in some instances longer than the effect of ephedrine solutions. When Privine HCL was employed for displacement

therapy in sinusitis, results were as satisfactory as with ephedrine in physiological saline. Instillation of the solution into the paranasal sinuses after irrigation had no definite effect on the sinus infection. The Privine HCL solution caused no local smarting or burning; it also caused none of the systemic effects sometimes observed with intranasal application of ephedrine, such as tremor, cardiac palpitation, or skin eruptions. The authors conclude that the use of Privine HCL in rhinologic practice has given "entirely satisfactory" results in their experience.

COMMENT

From personal experience, this new nasal vasoconstrictor seems to have a more lasting effect than any of those now commonly in use. The pH is correct. It apparently does not affect ciliary action. We have found that one must be careful to avoid overdosage, however, or undue general stimulation occurs. We have found the 0.05% solution more useful because of this factor. *L.C.McH.*

Histaminase Intramuscularly in Hay Fever

D. E. FRANK (*New York State Journal of Medicine*, 43:339, Feb. 15, 1943) reports the treatment of 85 patients with ragweed hay fever by intramuscular injections of histaminase. Of 85 patients treated by this method, only 69 could be adequately followed up; of these 69 patients, 44 had had pollen therapy in previous seasons and 25 had not. Patients treated in the month of July were given one injection weekly each of 4 units of histaminase; in the month of August two injections weekly of 4 to 6 units each were given until about August 20th, then the dosage was increased to 9 to 12 units every other day for patients who began to show hay fever symptoms. For patients beginning treatment after August 20th (coseasonal treatment), the dosage was 6 to 12 units daily or every other day. The total dosage was between 25 and 50 units in 80 per cent of patients; 90 per cent were given between five and ten injections. The follow-up of results showed that 39.1 per cent of the patients were benefited to some extent by the histaminase treatment, but "fair to excellent" results were obtained in only 28 per cent. The results were essentially the same with preseasonal and coseasonal treatment. A relatively higher percentage of patients who had not had previous pollen therapy obtained relief from the histaminase treatment (56 per cent) than those patients who had had successful pollen therapy in previous years (27.7 per cent). The local reaction to histaminase injection may be "quite painful"; occasionally there is a febrile reaction; the author has never observed any serious reaction, but does not consider the "indiscriminate use" of histaminase is justified. In his opinion, the results indicate that histaminase acts as a non-specific protein rather than as a specific enzyme detoxifying histamine.

COMMENT

We hope we may be still practicing rhinology after we finally discover why this person is allergic and that one is not. Until then we can only encourage those who are striving toward the discovery of practical therapy. *L.C.McH.*

Atrophic Rhinitis and Its Treatment by the Use of Estrogenic Substance

A. J. WAGERS (*Laryngoscope*, 37:391, March 1943) reports the treatment of 26 cases of atrophic rhinitis with estrogenic substance (amniotin) applied to the nasal mucous membrane. All these patients showed widened nares and drying and "crusting" in the nose; 13 had ozena; some complained of anosmia and others of headache. All patients were treated at the clinic once a week, amniotin (10,000 units) being applied after thorough cleansing of the nasal passages. Each patient was given a supply of the estrogenic substance to be applied in the nose by means of an atomizer after irrigating each nasal passage with two quarts of warm normal saline solution to which 4 gm. of sodium bicarbonate was added. These treatments were given at home three times daily for eight to twelve weeks, then once daily for two weeks or more. In some cases estrogen was discontinued if the nasal condition showed definite improvement, and only the daily irrigations continued. In 6 cases the crusting and ozena (if present) disappeared completely under treatment; in 12 cases there was definite improvement but some crusting persisted and ozena recurred occasionally. In the remaining 8 cases, there was no or slight improvement; the patients in this last group were somewhat irregular in both attendance at the clinic and their home treatment. Whether the improvement that is obtained with estrogen therapy will be permanent, cannot yet be determined; the author states that he

is "doubtful" in regard to permanent results.

COMMENT

Most of these patients are improved as long as they diligently keep their noses clean. Irrigations have seemed to be the most practical method of accomplishing this. Of course, local application of the estrogen preparation would be useless if the nose were not cleaned, but one is inclined to wonder how much of the benefit obtained was due to the cleansing and how much to the estrogen. *L.C.McH.*

A Survey of Antral Surgery—
Review of 100 Cases

R. H. STAHL, D. G. VOORHEES and R. T. DAVOL (*Laryngoscope*, 53:186, March, 1943) report a follow-up study of 50 cases in which the Caldwell-Luc operation was done and 50 cases in which antrostomy was done. The follow-up period was 6.6 months for the Caldwell-Luc operations and 6.7 months for the antrostomies. The operation was bilateral in 21 cases (4 Caldwell-Luc operations and 17 antrostomies). All but 4 patients were examined roentgenologically before operation and 85 per cent showed evidence of "thick membrane" or a cloudy antrum. The criterion of cure in the follow-up examinations was the obtaining of a clear "wash" on irrigation of the antrum. On this basis, cure was obtained in 54 per cent of the Caldwell-Luc operations and in 26 per cent of the antrostomies; in each group there were a few cases in which the wash was clear on most occasions but occasionally purulent (indicating "transient recurrences" of the antral infection). In a number of cases in which the antral wash was clear, symptoms were not relieved; further examination in these cases showed other conditions to be present that explained the symptoms—deviated septum, atrophic rhinitis, active infection of the ethmoid or frontal sinuses, and, in 2 cases, vasomotor rhinitis. On the other hand, there were a number of cases in which symptoms were relieved, but the antral washes were not clear. From the clinical point of view, symptoms were entirely relieved in 24 per cent of the patients after the Caldwell-Luc operation and there was definite improvement in an additional 28 per cent; after antrostomy symptoms were entirely relieved in only 6 per cent, and improved in 22 per cent. From these results the authors conclude that in cases of chronic maxillary sinusitis in which "the antral mucosa has passed beyond the reversible stage," the Caldwell-Luc operation gives the best chance of obtaining a healthy antrum and relief of symptoms, but antrostomy is "only an ameliorative procedure." They are of the opinion that "absence of absolute indication" for antral surgery was an important factor in the unsatisfactory results obtained in this series.

COMMENT

It is axiomatic that the success of any such surgical procedures depends upon accurate diagnosis, logical consideration of the end to be obtained by the surgical procedure, and then upon good technical surgical performance. Amelioration of local symptoms may be all that the patient desires and all that he needs. If one desires to remove a source of focal infection, such as a diseased antral mucosa that has "passed beyond the reversible stage," then the operative procedure must include complete removal of that mucosa. *L.C.McH.*

Local Use of Sulfanilamide
in Tonsillectomies

K. N. VICTOR (*Archives of Otolaryngology*, 37:438, March 1943) reports the local use of sulfanilamide after tonsillectomy in 25 patients, comparing results with 25 patients in whom tonsillectomy had been performed by the same methods, under similar conditions but without the use of sulfanilamide. In the cases in which sulfanilamide was used, a small amount of the drug in powder form was held by means of a sponge in firm contact with both tonsillar fossae for five minutes, immediately after operation. Eight hours later, "a thin layer" of sulfanilamide powder was applied to the fossae with a powder blower; this procedure was repeated twenty-four hours after operation. Not over 5 gm. sulfanilamide was used in each fossa in each application. A thin yellow film formed after each application but disappeared within three hours. In comparing the 25 cases in which sulfanilamide was used with the controls, the author finds that: There was no postoperative oozing and no positive blood cultures in the sulfanilamide treated group, as compared with 2 cases of postoperative oozing and 3 cases of positive blood cultures in the controls. There was less slough, less inflammatory reaction of the fossa and less soreness of the throat in the sulfanilamide treated group; and "complete convalescence" and healing took

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Medical BOOK NEWS

Edited by
ALFRED E. SHIPLEY, M.D., Dr. P.H.

All books for review and communications concerning Book News should be addressed to the Editor of this department, 1313 Bedford Avenue, Brooklyn, N. Y.

Classical Quotations

● **Whatever the future may reveal as to the causes of ulcer and the influences that retard its healing, . . . results . . . may be obtained by maintaining an efficient neutralision of free hydrochloric acid . . .**

Bertram W. Sippy

Relative Value of Medical and Surgical Treatment of Gastric and Duodenal Ulcer. *J.A.M.A.* 79:26-29 (July 1) 1922.

The Emotional Lives of Students

Mental Health in College. By Clements C. Fry, M.D. New York, The Commonwealth Fund, [c. 1942]. 365 pages, 8vo. Cloth, $2.00.

SOCIETY is deeply indebted to all of The Commonwealth Fund's publications, but the author ventures to say that none is more deserving of commendation than this book.

A decade of critically digested experience of Dr. Fry, who is psychiatrist to the Department of University Health of Yale, forms the basis of this number-one publication in its special field.

An open-minded reading of this experience-born book inevitably leads one to the conclusion that no college can escape its responsibility for the development of its students' emotional lives. If this be so, the psychiatrist is an indispensable asset in every educational institution.

FREDERICK L. PATRY

For the Jitters

You Must Relax. By Edmund Jacobson, M.D. New revised edition. New York, McGraw-Hill Book Company, Inc., [c. 1942]. 261 pages. 12mo. Cloth $1.75.

THIS book is written for the laity; it attempts throughout to express itself in language which the intelligent layman can understand. In this it succeeds admirably. The book enjoys the advantage of appearing at the so called "psychological moment." In this global war with its universal tenseness, a book by a known and esteemed writer with the title "You Must Relax" is to say the least attractive. The lay reader will be well repaid by its perusal; of the many suggestions, some scientific, others traditional, there surely is one or more that will be of help to every reader.

It would seem that there might be added to the list of suggestions, one that is, alack, too infrequently used, namely "Laughter."

S. R. BLATTEIS

Popular Sight Conservation

The Sight Saver. By C. J. Gerling, New York, Harvest House, [c. 1943]. 202 pages, 8vo. Cloth, $2.00.

THE Sight Saver is a small volume designed to supply the layman with varied information, definitions, etc., having to do with the eye and its diseases. In the reviewer's opinion, it will fill a long needed defect in its field. The material is arranged alphabetically but without an index or table of contents. The reviewer feels that the book is very much worth while. At the same time he wishes to point out that many of the descriptions and definitions are those of texts of twenty-five years ago. More modern views based on much better information could have been included.

Another defect is the fact that a great mass of information is included which is not generally accepted for the reason that it is the product, directly or indirectly, of

commercial interests. This applies particularly to the advice and material quoted on illumination. There are numerous such references included on pages 33 and 34 under the heading "Books on the eyes, sight, etc." Although there is a special heading on technical books, not one standard work on ophthalmology is included unless the manual for students is so considered.

The above criticism should not be regarded as condemning this work as it is definitely valuable and is well written.

JOHN N. EVANS

Practicing Medicine At Sea

Ship's Doctor. An Autobiography of a Surgeon at Sea. By Rufus W. Hooker, M.D. New York, Whittlesey House, McGraw-Hill Book Company, Inc., [c. 1943]. 279 pages. 8vo. Cloth, $2.50.

THIS book gives the interesting experiences of a doctor who was, as he prefers to be called, a "Ship Surgeon" for 14 years.

Dr. Hooker started as a general practitioner in a small Mexican town, followed by the practice of nose and throat diseases in Memphis, Tennessee. What was the psychology of his later wanderlust is not apparent. He speaks about his hope to finish with a home in California, but the end of the book finds the doctor "dodging danger on a transport.

Stories follow one another without any definite chronology, about the various types of patients encountered. A pertinent chapter on "Medicine in the Tropics" mentions such oriental novelties as Guam blisters, Hong Kong tummy and Ningpo varnish.

This is truly a story of the patient at sea.

JOSEPH RAPHAEL

An Anatomic Atlas

Manual of Human Cross Section Anatomy. By Dudley J. Morton, M.D., Raymond C. Truex, M.S. and Carl E. Kellner. Baltimore, Williams & Willkins Company, [c. 1941]. 249 pages, illustrated. Folio. Cloth, $6.00.

THE teaching of anatomy by cross section unquestionably is good, but the student often fails to get a correlation of the subject as a whole. This volume with its key figures, somewhat obviates this criticism.

So long as the student is required to do actual dissections, using the cross sections as an adjunct, a manual of cross section anatomy is most important. This volume, practicaly devoid of text, is arranged with key figures illustrating the continuity of the anatomical structures with the levels at which the sections are taken.

The book is somewhat cumbersome to take to and from class.

HERBERT T. WIKLE

Salvaging the Crippled and Injured

A Surgeon's Fight to Rebuild Men. An Autobiography by Fred H. Albee, M.D. New York, E. P. Dutton & Company, [c. 1943]. 349 pages, 8vo. Cloth, $3.50.

AFTER reading a Foreword by Lowell Thomas in which Dr. Albee is referred to as "one of the great surgeons of all times" and the "Burbank of Surgery," the reader is prepared for the story of an unusually active, fruitful and profitable life.

Not long after his interneship in the Massachusetts General, Dr. Albee had the inspiration to concentrate on orthopedic surgery. To facilitate his work he devised an electric bone drill, later developed into the instrument of precision so generally used today. Dr. Albee visioned the application of the principles of bone grafting, transplants and plastic surgery in the rehabilitation of soldiers in the First World War.

Planned as an autobiography, this book has developed into a saga of what orthopedic surgery has been able to accomplish in the "Rebuilding of Men."

JOSEPH RAPHAEL

The Tuberculous Patient

Rehabilitation of the Tuberculous. By H. A. Pattison, M.D. Livingston, N. Y., The Livingston Press, [c. 1942]. 186 pages, illustrated. 8vo. Half cloth, $2.50.

UNTIL recently no serious effort was made to rehabilitate large numbers of tuberculous patients in this country. It is not a simple thing; many factors enter into the problem.

In his book, Dr. Pattison tells in simple words some phases of the problem and cites interesting cases. He writes of sanatorium treatment, diversional therapy, and factors influencing recovery, such as allergy, immunity and constitution. His "Pattern for Rehabilitation" is graphically portrayed and should be instructive to both patient and physician. Mental aspects of tuberculosis are well covered, and marriage between tuberculous patients is discussed. In the second part of the book are chapters descriptive of rehabilitation centers and the work carried on.

This book should be read by all engaged in treating the tuberculous and by those supervising patients after discharge from sanatoria.

FRED H. HEISE

Resection of the Prostate

Endoscopic Prostatic Surgery. By Roger W. Barnes, M.D. St. Louis, The C. V. Mosby Company, [c. 1943]. 232 pages, illustrated. 8vo. Cloth, $6.00.

THIS is the first work on Endoscopic Prostatic Surgery that has come to the attention of the reviewer. The text is clear, concise and complete, with over 100 illustrations which add greatly to the work.

A chapter on the history is written by Dr. C. W. Collings, while another on "Punch Prostatectomy" has been contributed by Dr. H. C. Bumpus.

The author evidently is able to perform a truly complete prostatectomy as deep as the capsular structure, a technique not mastered by many.

The book, primarily intended for students of urology, urologic residents, and young practitioners of urology, also should prove valuable to experienced urologists.

AUGUSTUS HARRIS

Care of the Mentally Sick

Mental Illness: A Guide for the Family. By Edith M. Stern. New York, The Commonwealth Fund, [c. 1942]. 134 pages. 8 vo. Cloth, $1.00.

THIS book fills a long-felt need. Herein may be found information of a practical sort to guide laymen more or less responsible for the care and treatment of those near and dear to them, who suffer from varying degrees of mental illness. It expertly fulfills the expectation implied in the sub-title "A Guide for the Family." In this simple and lucid presentation of the essential understanding and management of mentally sick persons, the family may find insight whereby intelligent cooperation with the family physician and phychiatrist may be obtained. The significance and importance of signs and symptoms of mental sickness bring to mind further questions concerning the need of hospitalization and if so the proper use of a private or public mental hospital. The trying procedure of getting the patient admitted is intelligently and tactfully handled. In fact, all the various steps necessarily involved from admission, through hospitalization, preparation for discharge, family after-care to rehabilitation are masterly dealt with in language easily comprehended and authoritatively formulated.

An important contribution of this small book is the inculcation of a healthy attitude toward mental illness. The door is opened whereby we all can further the cause of mental hygiene through cooperating with local, state and national mental hygiene committees and associations. Suggestions are given whereby the patient's stay in mental hospitals may be brightened. Attention is brought to support of legislation which aims at improving the facilities designed to more adequately take care of this ever-growing and real problem and obligation of enlightened citizenship.

Hospital administrators, physicians, psychiatrists, social workers, clergymen, educators, and all those consulted and concerned in matters of family care and welfare will want to make known this unique publication. It stands without peer in downright practical usefulness.

FREDERICK L. PATRY.

Hepatology

Diseases of the Liver, Gallbladder and Bile Ducts. By S. S. Lichtman, M.D. Philadelphia, Lea & Febiger, [c. 1942]. 906 pages, illustrated. 8vo. Cloth, $11.00.

THIS exhaustive work on Hepatology is probably the most important contribution to the subject which has so far appeared. It is not only a compilation of the essential contributions of other workers whose works are freely quoted, but it also represents a vast, intelligent clinical research by the author.

As a whole the book is thoroughly readable; useless illustrations have been avoided, and bibliographies have been placed at the end of chapters. It is a book for the student, the general practitioner, the specialist, and the surgeon.

A. F. R. ANDRESEN

Pediatrics in Brief

A Handbook on Diseases of Children Including Dietetics and the Common Fevers. By Bruce Williamson, M.D. Third edition. Baltimore, Williams and Wilkins Company, [c. 1942]. 364 pages, illustrated. 12mo. Cloth, $4.50.

THIS book which gives a short resumé of the common diseases of childhood, is really too brief to be of much practical value.

For quick reference, the busy practi-

tioners in small communities may find this volume of some value; but in large cities with medical libraries so convenient, the average physician may find more satisfaction in books which consider their topics more in detail.

THURMAN B. GIVAN

A New Theory on Pain

Referred Pain: A New Hypothesis. By G. W. Theobald, M.D. London, Blackfriars House, [c. 1941]. 40 pages, illustrated. 4to. Paper 3s.

IN this thesis the author discusses hypotheses of pain such as those of Mackenzie, Lennander and Morley.

Part of the suggested hypothesis of referred pain is that it arises from the direct stimulation of cells in the pain apperception centre in the brain. Pain, it is stated, may be referred not only from the distribution of one cranial nerve to another, but also from a cranial nerve to cutaneous areas supplied by the upper cervical nerves.

The discussion is rather involved and will be of interest principally to the neurologist.

W. E. MCCOLLOM

BOOKS RECEIVED *for review are promptly acknowledged in this column; we assume no other obligation in return for the courtesy of those sending us the same. In most cases, review notes will be promptly published shortly after acknowledgment of receipt has been made in this column.*

Methods for Diagnostic Bacteriology. By Isabelle G. Schaub, A. B. and M. Kathleen Foley, A.B. 2nd Edition. St. Louis, C. V. Mosby Company, [c. 1943]. 430 pages. 8vo. Cloth, $3.50.

Hope Deferred. By Jeanette Seletz. New York, The Macmillan Company, [c. 1943]. 536 pages. 8vo. Cloth, $2.75.

Victories of Army Medicine. Scientific Accomplishments of the Medical Department of the United States Army. By Edgar Erskine Hume, Col., M.C., U.S.A. Philadelphia, J. B. Lippincott Company, [c. 1943]. 250 pages, illustrated. 8vo. Cloth, $3.00.

Discovering Ourselves. A View of the Human Mind and How It Works. By Edward A. Strecker, M.D., & Kenneth E. Appel, M.D., in collaboration with John W. Appel, M.D. 2nd Edition. New York, The Macmillan Company, [c. 1943]. 434 pages. 8vo. Cloth, $3.00.

Dictionary of Bio-Chemistry and Related Subjects. William Marias Malisoff, Editor-in-Chief. New York, Philosophical Library, Inc., [c. 1943]. 579 pages. 8vo. Cloth, $7.50.

Man in Structure and Function. By Fritz Kahn, M.D. Translated from the German and edited by George Rosen, M.D. Volumes I and II. New York, Alfred A. Knopf, Inc., [c. 1943]. 742 pages, illustrated. 8vo. Cloth, $10.00.

Neurosurgery and Thoracic Surgery. [Military Surgical Manuals Vol. VI]. Prepared and Edited by the Subcommittees on Neurosurgery and Thoracic Surgery of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. Philadelphia, W. B. Saunders Company, [c. 1943]. 310 pages, illustrated. 8vo. Cloth, $2.50.

Gynecology, with a Section on Female Urology. By Lawrence R. Wharton, M.D. Philadelphia, W. B. Saunders Company, [c. 1943]. 1006 pages, illustrated. 8vo. Cloth, $10.00.

Doctor in the Making. The Art of Being a Medical Student. By Arthur W. Hamm, M.B. and M.D., Salter, Ph.D. Philadelphia, J. B. Lippincott Company, [c. 1943]. 179 pages, illustrated. 12mo. Cloth, $2.00.

CONTEMPORARY PROGRESS

—Concluded from page 228

place several days earlier than in the control group. While the results obtained indicate that the local use of sulfanilamide after tonsillectomy has several definite advantages, the series of cases studied is too small to permit definite conclusions, and the author is carrying out further studies with this procedure.

COMMENT

We are seeing an increasing number of patients who have become sensitized to the sulfonamide drugs. This has made us loath to use them in conditions where morbidity is not usually high and where complications are not greatly to be feared. We do not minimize the morbidity in the usual adult patient following tonsillectomy and have long thought that superficial infection in the fossae is a large factor. This may prove to be a useful procedure. *L.C.McH.*